

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08240

8264

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First LOLA	Middle HURLEY	Last ABBOTT	4. DATE OF DEATH August 29 1956	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Nov. 9, 1886	9. AGE (in years last birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Salem, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Newton Hurley		14. MOTHER'S MAIDEN NAME Not Known						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Willie Reeder Cambridge, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerosis (c) DUE TO Hypertension						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day 8/29	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 104 Locust St Cambridge	20f. (City or town) Locust Street	(County) Cambridge	(State) Maryland
21. I certify that I attended the deceased from 8/29/56 to 8/29/56, that I last saw the deceased alive on 8/29/56, and that death occurred at 970 Locust Street, Cambridge, Maryland, from the causes and on the date stated above.						ADDRESS (Street, city, town, state) M.D. 104 Locust St Cambridge	DATE SIGNED 8/31/56	
ACTUAL SIGNATURE <i>W.H. Hanks</i>		PHYSICIAN'S NAME (Type) Dr. William H. Hanks M.D.		Locust Street Cambridge, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/2/56		22c. NAME OF CEMETERY OR CREMATORIAL Sandy Island Cemetery		22d. LOCATION (City, town, or county) Andrews Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Maryland		24a. REC'D BY REGISTRAR LeCompte		24b. REGISTRAR'S SIGNATURE LeCompte R.D.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DESERVING

BUREAU V. S

SEP 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8265 08241

116

8265

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge General Hospital		d. STREET ADDRESS Poplar St. (
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FRED	Middle SPENCER	Last ALBRO
4. DATE OF DEATH	Month AUGUST	Day 4	Year th 19 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1881
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing		10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (State or foreign country) New York
13. FATHER'S NAME No Record		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Albert Jones 131 Clyde Ave. (Fruitland) Salisbury, Maryland Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Coronary embolus		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Colitis, non-specific	
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day Not while at work	Year at work
20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 136 Race St	(County) Cambridge, Maryland
21. I certify that I attended the deceased from 7/2 , 19 56 , to 8/4 , 19 56 , that I last saw the deceased alive on 8/4 , 19 56 , and that death occurred at 12:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 Race St DATE SIGNED August 6, 1956			
ACTUAL SIGNATURE <i>Alfred R. Maryanov</i>	PHYSICIAN'S NAME (Type) Dr. Alfred R. Maryanov M.D.	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Aug. 7, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park	22d. LOCATION (City, town, or county) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME & SALISBURY, MD.	ADDRESS Albion	24a. REC'D BY REGISTRAR 1956	24b. REGISTRAR'S SIGNATURE <i>John Mace, Jr.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit Permit. Then please replace carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK

BUREAU Y.

JUG 9 1956

RECEIVED

18242

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2, See: Birth Cert.
8265 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

COUNTY Dorchester

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN Cambridge

LENGTH OF STAY
(In this place)

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Cambridge Md Hospital

3. NAME OF
DECEASED:

(First) Joyce
(Type or Print) Baby Girl

(Middle) Ann

(Last) Cephas

4. DATE (Month)
OF
DEATH: 8

(Day) 28

(Year) 1956

5. SEX:

F

6. COLOR OR
RACE:
Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify):

8. DATE OF BIRTH:
8-28-56

9. AGE last birthday

IF UNDER 1 YEAR
yrs. Months Days Hours Min.

2 2 2 2

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):

10B. KIND OF BUSINESS
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

Robert Cephas

14. MOTHER'S MAIDEN NAME:

Margaret Cornish

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates
of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: 234 High St

Margaret Cornish-Cambridge, Md.

18. MEDICAL CERTIFICATION
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

IMMEDIATE CAUSE

(A) Alelectasis

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

Premature-weight 16oz

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory,
OR INJURY street, office bldg., etc.)

21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED
While Not while
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-28-56 19... to 8-28-56 19... that I last saw the deceased

alive on 19..., and that death occurred at ...

M, from the causes and on the date stated above,
ADDRESS DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or County)

(State)

Burial Aug. 28 '56

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

Aug. 28, 1956

John Pace Jr. B. S.

Robert Cephas, Cambridge, Md.

RECEIVED
BUREAU V. A.

SEP 4 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8281

CERTIFICATE OF DEATH

118243
7/16

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 757 S. Division Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22-12-2									
3. NAME OF DECEASED (Type or print) Belle (Isabel) Amanda		First	Middle	Last	4. DATE OF DEATH Corbin	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	B. DATE OF BIRTH 5-10-63	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland (Somerset Co.)		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Levin Atkinson		14. MOTHER'S MAIDEN NAME Adeline Riller							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - - -		17. INFORMANT Mr. William F. Corbin (Son) 749 S. Div. St.		RECORDS: Eastern Shore State Hospital Salisbury			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage		DUE TO Generalized Arteriosclerosis		INT. MARYLAND ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Unknown		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Atkinson Family Cemetery		20f. (City or town) R.D. # Princess Anne, Maryland		(County) Wicomico (State) Maryland	
21. I certify that I attended the deceased from July 19, 1956 to August 1, 1956 that I last saw the deceased alive on August 1, 1956 , and that death occurred at 11:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thomas J. Dredge, M.D.								DATE SIGNED John Mace, Jr.	
ACTUAL SIGNATURE Thomas J. Dredge									
PHYSICIAN'S NAME (Type) Thomas J. Dredge, M.D.		E.S.S. Hospital, Cambridge, Md. August 1, 1956							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 3, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Atkinson Family Cemetery		22d. LOCATION (City, town, or county) R.D. # Princess Anne, Maryland		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME * SALISBURY, MD		ADDRESS 118-12-2		24a. REC'D BY REGISTRAR John Mace, Jr.		24b. REGISTRAR'S SIGNATURE John Mace, Jr.			
VS A15 (4) 15M 9/55									

BUREAU Y. 2

AUG 3 1956

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1824416

8282

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 43 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland		b. COUNTY Queen Anne's	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM		First	Middle	Last	4. DATE OF DEATH Aug.	Month	Day	Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/16/82	9. AGE (In years from birth) 73	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Robert Council		14. MOTHER'S MAIDEN NAME Amy Guessford							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> unknown		16. SOCIAL SECURITY NO. <input type="checkbox"/> none		17. INFORMANT Eastern Shore State Hospital records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Bronchopneumonia DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12/15, 1952, to 8/15, 1956, that I last saw the deceased alive on 8/15, 1956, and that death occurred at 3:20 p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE Thomas J. Dredge PHYSICIAN'S NAME (Type)		M.D. E.S.S. Hospital, Cambridge, Md. 8/15/56							
22a. BURIAL, CREMATION, MOVAL (Specify) Burial		22b. DATE THEREOF Aug 17-1956		22c. NAME OF CEMETERY OR Crematory Chesterfield		22d. LOCATION (City, town, or county) Centreville Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John H. Beving, Jr. Beving Bros. Centreville Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 8-18-56		24b. REGISTRAR'S SIGNATURE Eliza Brannettous John Mace, Jus.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILMINGTON STATE OF DELAWARE - DIVISION OF
CERTIFICATE OF DEATH

GENEVA 3-1115

WATSON

BUREAU V. S.

AUG 22 1956

RECEIVED
GARRETTE

1956 AUG 22 1956 CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18245

8283

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 27 yr. 11 mo. 18 da	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. STREET ADDRESS -	
3. NAME OF DECEASED (Type or print) Nelson		First - Coursey	Middle - Last Month Day Year August 9 19 56
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-02 (?)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John Coursey		14. MOTHER'S MAIDEN NAME Mary Hurt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	17. INFORMANT RECORDS: Eastern Shore State Hospital
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lobar Pneumonia DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 2 wks.			
3 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 1, 1951, to August 9, 1956, that I last saw the deceased alive on August 9, 1956, and that death occurred at 7:32 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>George E. Currier</i> PHYSICIAN'S NAME (Type) George E. Currier, M.D.			
22a. BURIAL, CREMATION, BURIAL (BROKEN) Burial		22b. DATE THEREOF Aug 10, 1956	22c. NAME OF CEMETERY OR Crematory Cambridge
22d. LOCATION (City, town, or county) Cambridge		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Reatha R. Thomas, Cambridge, Md.		24a. REC'D BY REGISTRAR Aug. 10, 1956	24b. REGISTRAR'S SIGNATURE John H. H. Ph. D.
ADDRESS		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. C.

AUG 16 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filmed 2-1-56

18246

Reg. Dist. No. 116

8267

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

COUNTY Dorchester

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN CambridgeLENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS Cambridge Md Hospital3. NAME OF
DECEASED:
(Type or Print) Harrison

(Middle)

(Last)

DeShields

4. DATE (Month) (Day) (Year)

OF
DEATH: 8

13 19 56

5. SEX: 6. COLOR OR
RACE: 7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify): widowed

Male Negro

8. DATE OF BIRTH:

9. AGE last birthday

10. UNDER 1 YEAR

Months

Days

11. UNDER 24 HRS.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired): Laborer10B. KIND OF BUSINESS
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?

Wicomico-Co-Md.

USA

13. FATHER'S NAME:

unk

14. MOTHER'S MAIDEN NAME:

unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates
of service)

16. SOCIAL SECURITY NO.

unk

unk

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) DUE TO	Acute Granulocytic Leukemia
ANTECEDENT CAUSE (B)	(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES

NO

(State)

(County)

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town)

(If either, notify medical examiner)

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While Not while at work at work 22. I hereby certify that I attended the deceased from 23 Jul 1956 to 13 Aug 1956, that I last saw the deceased
alive on Aug 13, 1956, and that death occurred at M. from the causes and on the date stated above.
SIGNATURE J. Edwin Fassett, M.D. ADDRESS 227 Pine St-Camb., Md. DATE SIGNED 8-13-56

23 BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)	(State)
Burial	8-16-1956	Cemetery in Nanticoke, Md.	Wicomico County	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
Aug 16, 1956	J. Edwin Fassett, M.D.	ADDRESS		

BUREAU V. S.

AUG 20 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8268

18247

Reg. Dist. No.

116

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, interment, or removal.

VS. AISM(E)5
SM 9/55

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)									
Dorchester		a. STATE Md.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Dorchester									
Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
d. LENGTH OF STAY IN 1b		d. STREET ADDRESS									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle								
E. J. Lubank		L	J. A. K.								
4. DATE OF DEATH		Month	Day								
Sept. 20, 1897		11	15								
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.		
Male		Negro	WIDOWED <input checked="" type="checkbox"/>	Divorced <input type="checkbox"/>	Sept. 20, 1897	0 yrs.	0 months	0 days	0 min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Retired				Kentucky		USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Cretcher Lubank		Mary Beauchamp									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
(If yes, give war or dates of service)				Herbert St. Clair, Cambridge, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion											
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)									
DUE TO											
		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								DATE SIGNED 17, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)			
Burial		Sept. 21, 1956		Cambridge Cemetery		Cambridge, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Herbert St. Clair, Cambridge, Md.				Date 17, 1956		John Beauchamp, M.D.					

BLAZA V. 8

19. 11. 1936

PERGELIVE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial (cremation, if removal).

VS. ATSMF(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8284 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118248

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) nr. Cambridge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 319 Choptank Ave		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 50 Choptank River Bridge				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JULIA		First	Middle	Last	4. DATE OF DEATH August 30 1956	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/27/1941	9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James E. Fairbanks				14. MOTHER'S MAIDEN NAME Elsie Bell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. James E. Fairbanks Bridgeville, Del.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contusion of Brain 819X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) - DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 i.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) I on car in out post on trip, I stay in						
20c. TIME OF INJURY Hour a. m. 11 p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) I on car in out post on trip, I stay in	20f. (City or town) Cambridge	(County) Maryland	(State) Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) Dr. John Mace Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/1/56		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Maryland		24a. REC'D BY REGISTRAR Aug. 31, 1956		24b. REGISTRAR'S SIGNATURE John Mace, A.D.		

RECEIVED
SURREAU V. S.

SEP 4 1966

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

108249

8269 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 116

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, removal, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 15 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambria General Hospital, Cambridge		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Eliza		First	Middle	Last	4. DATE OF DEATH Aug. 20, 1956	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 32 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) one		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Grenville Lewis		14. MOTHER'S MAIDEN NAME Mary Lynch							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Grenville Fowler		Address East New Market			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 1 instant			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Fracture neck 1 + 2, r. 8/21/56</i>		(b)							
DUE TO <i>Slipped and fell in hole</i>		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell in hole							
20c. TIME OF INJURY Month, Day, Year Hour 6:00 P.M. - 12-19-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Arlington		20f. (City or town) Arlington		(County) Arlington	(State) Virginia
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>John Lee Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/21/56			
EXAMINER'S NAME (Type) John Lee Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-31-56		22b. DATE THEREOF 8-31-56		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee's Funeral Home		ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DATE Aug. 30, 1956		24b. REGISTRAR'S SIGNATURE John Lee, D.S.			

BUREAU V. 4

SEP 5 1956

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18250

8270

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Items 7, 11 Film 1429 Reg. Dist. No. 11											
MARYLAND		Md.		Dorchester											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
Dorchester		14 B. 32		Burlock											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
Campbell's Industrial Hospital		Pillar Labor Co.													
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year							
George		T	T	T	19	, , ,	, , ,	, , ,							
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 24 HRS. Months Days Hours Min.					
M		White		about		50 yrs.		50 yrs.		00 hrs. 00 min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?						
Laborer			None			Blytheville, Ark.			None						
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			
John			Unk.			None			None			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bullet in mind of brain												71			
DUE TO															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)															
DUE TO															
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) He was shot through head.												
20c. TIME OF INJURY Month, Day, Year Hour			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)		(County)		(State)		
Aug 12			11:00 - 1												
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE		<i>John Moore</i>										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE									

1966 8/23

AUG 23 1966

1966 8/23

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 18251
Items 1, 11, 13, 9-1-53
8271 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

COUNTY Dorchester

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN Cambridge

MARYLAND

LENGTH OF STAY
(in this place)

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Cambridge Md Hospital

3. NAME OF DECEASED: (First) (Middle) (Last)

Richard

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY Dorchester

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Cambridge

STREET
ADDRESS

(If rural give location)

205 Washington St

3. SEX: 6. COLOR OR RACE: 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

Male

Negro

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): railroad track-man

8. DATE OF BIRTH:

1910-10-14

10B. KIND OF BUSINESS OR INDUSTRY:

4. DATE (Month) (Day) (Year)
OF DEATH: 8 29 1956

9. AGE last birthday
yrs. Months Days Hours Min.

10. BIRTHPLACE (State or foreign country): 11. CITIZEN OF WHAT COUNTRY?

Virginia

13. FATHER'S NAME:

Aubrey Hayden

14. MOTHER'S MAIDEN NAME:

Mary Beckst (dates)
Suzie J. Jones. 205 Washington St.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unk.) (If Yes, give war or dates of service)

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

IMMEDIATE CAUSE

(A) Cerebral Hemorrhage

ANTECEDENT CAUSE (S):

DUE TO

(B) Arteriosclerotic heart disease

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?

While Not while
M. at work at work

22. I hereby certify that I attended the deceased from Jul 14, 1953 to Aug 29, 1956, that I last saw the deceased alive on Aug 29 1956 and that death occurred at M, from the causes and on the date stated above.
SIGNATURE: *Edwin Fassett* ADDRESS: DATE SIGNED: *1956*

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORIAL REMOVAL (Specify) LOCATION (City, town or county) (State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

DATE REC'D BY LOCAL REGISTRAR: *Sept 1, 1956* REGISTRAR'S SIGNATURE: *John Hale, Jr. D. S.* FUNERAL DIRECTOR: *George O. Holmes* ADDRESS: *205 Washington St. Cambridge, Md*

BUREAU V

SEP 5 1956

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8285

CERTIFICATE OF DEATH

118252

Reg. Dist. No. 716

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 16 since 1/31/30		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Isabelle		First	Middle	Last	4. DATE OF DEATH Hubbard	Month August	Day 8	Year 19 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1858	9. AGE (In years last birthday) 98 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or Foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Jesse Hubbard		14. MOTHER'S MAIDEN NAME Catherine Frampton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Eastern Shore State Hospital Records		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH 3 days		
		Chronic Myocarditis				several years		
		Generalized Arteriosclerosis				several years		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Senile Psychosis						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Dec. 1, 1951, to August 8, 1956, that I last saw the deceased alive on August 8, 1956, and that death occurred at 10:00PM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE Robert H. Reddick						DATE SIGNED 8/8/56		
PHYSICIAN'S NAME (Type) Robert H. Reddick, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Aug 10, 56		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL Gravemount		22d. LOCATION (City, town, or county) Hedges		(State)
23. FUNERAL DIRECTOR'S SIGNATURE John H. Reddick		ADDRESS		24a. REC'D. BY REGISTRAR John H. Reddick		24b. REGISTRAR'S SIGNATURE John H. Reddick		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

AUG 16 1956

REF ID: A640

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8286 CERTIFICATE OF DEATH

18253
Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		b. ANNUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Belvoir (rural)</i>		b. COUNTY <i>Dor</i>	
c. LENGTH OF STAY IN 1B <i>all life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Vienna (rural)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cambridge Maryland</i>		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) <i>Alfred</i>		4. FIRST MIDDLE <i>- Hurley</i>	4. DATE OF DEATH <i>8/12/56</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>2/1/1870</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>A. S.A.</i>	
13. FATHER'S NAME <i>Alfred Hurley</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Stanley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Arteriosclerosis (Coronary) Heart Disease 4 months			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerosis hepatitis 8 days (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/12/56</i> , 19, to <i>8/12/56</i> , 19, that I last saw the deceased alive on <i>8/12/56</i> , 19, and that death occurred at <i>6:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lawrence Maryland</i>		ADDRESS (Street, city or town, state) <i>136 Rae St.</i>	
PHYSICIAN'S NAME (Type) <i>Lawrence Maryland</i>		DATE SIGNED <i>Cambridge, Md</i>	
22. BURIAL, Cremation, or Removal (Specify) <i>Burial 8/14/56</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Methodist</i>	
22d. LOCATION (City, town, or county) <i>Vienna</i>		(State) <i>2nd</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ruth S. Moulton</i>		24a. REG'D BY REGISTRAR DATE <i>Aug 14, 1956</i>	
ADDRESS <i>611 Market</i>		24b. REGISTRAR'S SIGNATURE <i>John May 115</i>	

RECEIVED
BUREAU V. 3

UG 16 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 18254

8287

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 1 yr. 8 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle HUTLEY	4. DATE OF DEATH Aug. 9 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/12/86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Neilton Hurley		14. MOTHER'S MAIDEN NAME Willie Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. unkn.	17. INFORMANT - Eastern Shore State Hospital records
Address			12. CITIZEN OF WHAT COUNTRY? U.S.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of prostate</u> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 16</u> , 19 <u>54</u> , to <u>Aug. 9</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Aug. 9</u> , 19 <u>56</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. E.S.S. Hospital, Cambridge, Md. 8/10/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/12/56	22c. NAME OF CEMETERY OR CREMATORIAL SANDY ISLAND
23. FUNERAL DIRECTOR'S SIGNATURE F. E. SMITH, FUNERAL SERVICE		ADDRESS JAMBROOK	22d. LOCATION (City, town, or county) ROBBINS MD
24a. REC'D BY REGISTRAR DATE Aug. 11 1956		24b. REGISTRAR'S SIGNATURE John H. S.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

RECEIVED
BUREAU N.Y.

AUG 14 1936

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18255

CERTIFICATE OF DEATH

Reg. Dist. No. 16

8272

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 45 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 3 Cedar Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital (4 days)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JAMES	Middle IRVING	Last HURLEY SR.	4. DATE OF DEATH August 17 1956	Month August	Day 17	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/29/1869	9. AGE (In years from birth) 86	10. IF UNDER 1 YEAR Months 86	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Hurley				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT J. Irving Hurley Jr. Cambridge, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				Carcinoma of stomach with obstruction		INTERVAL BETWEEN ONSET AND DEATH 3yless	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Right inguinal hernia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1:10 a.m. 1956 to 1:00 p.m. 1956					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 10	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Locust Street Cambridge, Maryland	20f. (City or town) Cambridge	(County) None	(State) None
21. I certify that I attended the deceased from 1:10 a.m. 1956 to 1:00 p.m. 1956 that I last saw the deceased alive on 1:10 a.m. 1956 , and that death occurred at 1:00 p.m. 1956 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Locust St Cambridge, Md.							
ACTUAL SIGNATURE 	DATE SIGNED 8/14/56						
PHYSICIAN'S NAME (Type) Dr. William H. Hanks M.D.	Locust Street Cambridge, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/20/56	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park	22d. LOCATION (City, town, or county) Cambridge, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Maryland	24a. REC'D BY REGISTRAR Aug. 20, 1956		24b. REGISTRAR'S SIGNATURE John Pace R.S.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

204720 V. 2

AUG 29 1956

DECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8288

CERTIFICATE OF DEATH

118256
116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First OLIVIA	Middle	Last	4. DATE OF DEATH	Month Aug.	Day 9	Year 19 56
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9/20/72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13. FATHER'S NAME James Henry Smullen	14. MOTHER'S MAIDEN NAME Elizabeth Brumley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Eastern Shore State Hospital records	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary thrombosis	INTERVAL BETWEEN ONSET AND DEATH duration unknown
+ C 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Generalized arteriosclerosis	

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile Psychosis	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/17/55 , 19, to 8/9/56 , 19, that I last saw the deceased alive on Aug. 9 , 19 56 , and that death occurred at 1:15p , M, from the causes and on the date stated above.
--

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE <i>Thomas J. Dredge</i>	M.D. E.S.S. Hospital, Cambridge, Md. 8/9/56
PHYSICIAN'S NAME (Type) Thomas J. Dredge	

22a. BURIAL, CREMATION, REMOVAL (Specify) 5-12-56	22b. DATE THEREOF 5-12-56	22c. NAME OF CEMETERY OR CREMATORIUM Allen	22d. LOCATION (City, town, or county) Allen, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Dale Dashiell's Princess Anne Md</i>	ADDRESS 116	24a. REC'D BY REGISTRAR John Maca Jr.	24b. REGISTRAR'S SIGNATURE
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May 13 1956

May 13 1956

May 13 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08257

8289

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 116

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Dorchester MARYLAND		b. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linas Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linas Road	
c. LENGTH OF STAY IN 1b 10 days		d. STREET ADDRESS Linas Road, Church Creek	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Addison	Middle Johnson
4. DATE OF DEATH		Month Aug.	Day 24, Year 1956
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
Male Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May 23, 1953
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
None		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		Dorchester Co., Md. USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Addison Johnson, Sr.		Monenia Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
-----		None	
17. INFORMANT		Address	
Addison Johnson, Sr., Linas Road, Md.		INTERVAL BETWEEN ONSET AND DEATH Instant	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns entire body			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
Inhalation of hot oil		20c. TIME OF INJURY Month, Day, Year Hour a. m. 10 a.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Church Creek		(County)	
		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John Monroe		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED Aug. 27, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/27/1956	
22c. NAME OF CEMETERY OR CREMATORIAL Linas Road		22d. LOCATION (City, town, or county) Linas Road, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE K. M. Wallace Jr.		ADDRESS Cambridge, Md.	
		24a. REC'D BY REGISTRAR John H. Lee, A.S.	
		24b. REGISTRAR'S SIGNATURE	

READY FILE

123-22 1956

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FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8273 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18258

Reg. Dist. No. 116

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, removal, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
3. NAME OF DECEASED (Type or print) MARIE		First WARD	Middle JOHNSON		
4. DATE OF DEATH August 2, 1956		Last JOHNSON	Month Day Year		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1918		
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Month Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife			
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Ward		14. MOTHER'S MAIDEN NAME Marie Askins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. None			
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative encephalopathy DUE TO 1.8 Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause (c) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE ALFRED R. MARYANOV	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/6/56		
EXAMINER'S NAME (Type) ALFRED R. MARYANOV	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/12/1956	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Waugh Cemetery	22d. LOCATION (City, town, or county) Cambridge, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lee, Jr.	24a. REC'D BY REGISTRAR DATE Sept. 6, 1956		24b. REGISTRAR'S SIGNATURE John J. Lee, Jr.		

BUREAU Y. S.

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08259

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8290 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 116

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in block in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tranport permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Dorchester MARYLAND		a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Linas Road		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Linas Road, Cambridge, Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Wendy	Middle Dorine
4. DATE OF DEATH		Last Johnson	Month Aug. Day 24, Year 1956
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
Female Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
None		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Addison Johnson, Sr.		Monenia Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
-----		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Initial	
9/6/56		Burns entire body	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 11 a.m. p. m. 11/13/56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
SIGNATURE John M. Johnson		DATE SIGNED 10/27/56	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/27/1956	
22c. NAME OF CEMETERY OR CREMATORIALY Linas Road		22d. LOCATION (City, town, or county) (State) Linas Road, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Cambridge, Md.	
		24a. REC'D BY REGISTRAR John Race, A.D. DATE Aug. 27, 1956	
		24b. REGISTRAR'S SIGNATURE	

TUREAU V. G.

AUG 30 1956

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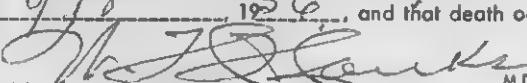
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118260

8274

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wingate		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 210 Academy St. (Home of Son)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First MELVIN		Middle R.	Last JONES	4. DATE OF DEATH	Month August	Day 18	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 14, 1873	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 83	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Wingate, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jacob T. Jones			14. MOTHER'S MAIDEN NAME Mary Ann Tall					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Ernie E. Jones		Address Cambridge, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 8 days								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. p. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 930 P.M.	20f. (City or town) Cambridge	(County) Md.	(State) Md.	
21. I certify that I attended the deceased from 7/18 , 19 56 , to 7/18 , 19 56 , that I last saw the deceased alive on 7/18 , 19 56 , and that death occurred at 930 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Locust Street Cambridge, Md. DATE SIGNED 8/29/56								
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) Dr. William H. Hanks M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/22/56	22c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		22d. LOCATION (City, town, or county) Cambridge, Maryland			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Maryland		24a. REC'D BY REGISTRAR Aug 22, 1956	24b. REGISTRAR'S SIGNATURE John H. Hanks, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove carbon copies. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU Y. S.

Aug 29 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

108261

Reg. Dist. No. 116

8275

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 341 Purside street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Long Wharf, Main Street, Cambridge, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Delfin		4. DATE OF DEATH Mac'ite Month Day Year August 5 1956					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 24, 1896	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steward, live a taur s ip		10b. KIND OF BUSINESS OR INDUSTRY Potomac		11. BIRTHPLACE (State or foreign country) Manilla, P.I.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> If yes, give war or dates of service 1918-1948		16. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth R.achite,		Address 341 Purside St. Annapolis, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH unknown			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4683.1 <i>Coronary embolus</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c)				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Annapolis, Md. Anne Arundel, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE ALFRED R. MARYANOV		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 8, 1956		22c. NAME OF CEMETERY OR CREMATORIUM National Cemetery		22d. LOCATION (City, town, or county) Annapolis, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John Taylor & Sons, Annapolis, Md.				24a. REC'D BY REGISTRAR DATE Aug. 7, 1956		24b. REGISTRAR'S SIGNATURE John Taylor, Jr. (H. B.)	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certifying physician, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial or removal.

NUMBER 117

UG 9 1956



MARYLAND STATE DEPARTMENT OF HEALTH

68262

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		d. STREET ADDRESS R.F.D. # 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) INFANT		First	Middle	Last	4. DATE OF DEATH Mc COLLISTER	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1956	9. AGE (in years last birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None Infant		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Dorsey E. Mc Collister		14. MOTHER'S MAIDEN NAME Madonna Arnett							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Dorsey E. Mc Collister		Address Cambridge, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cerebral Anoxia - etc. in utero		INTERVAL BETWEEN ONSET AND DEATH 3 days			
(b)		DUE TO Post Mortem				—			
(c)		DUE TO Erythroblastosis Fetalis				6 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that I attended the deceased from <u>8-23-56</u> , to <u>8-26-56</u> , that I last saw the deceased alive on <u>8-26-56</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <u>Cambridge, Md 8-27-56</u>			
ACTUAL SIGNATURE <u>Dr. William N. Baumann</u>		M.D.							
PHYSICIAN'S NAME (Type) Dr. William N. Baumann M.D.		3 Church Street, Cambridge, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 27, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park	22d. LOCATION (City, town, or county) Cambridge, Maryland						
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Maryland		24a. REGD BY REGISTRAR Date <u>Aug 27 1956</u>	24b. REGISTRAR'S SIGNATURE John H. D.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Bureau X E

AUG 30 1956

REGISTRATION

8277

CERTIFICATE OF DEATH

18263

Reg. Dist. No. 116

1. PLACE OF DEATH:

COUNTY Dorchester

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)LENGTH OF STAY
(in this place)

TOWN Cambridge

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

9 School House Lane

3. NAME OF
DECEASED:
(Type or Print)4. SEX:
MaleCOLOR OR
RACE:
Negro

(First)

(Middle)

(Last)

7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify):8. DATE OF BIRTH:
Single July 15, 188710A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):

None

10B. KIND OF BUSINESS
OR INDUSTRY:

None

9. AGE last birthday

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

69

0

18

13. FATHER'S NAME:

Isiah Opher

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unk.) (If Yes, give war or dates
of service)

No

16. SOCIAL SECURITY NO.

None

Sarah Nichols

17. INFORMANT & ADDRESS:

Solomon Opher, Cambridge, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

IMMEDIATE CAUSE

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSE (B)

(B) Cardiac Decompensation

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
While Not while
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 9, 1953, to Aug. 13, 1956, that I last saw the deceased
alive on Aug 13, 1956 and that death occurred at *Cambridge* M., from the causes and on the date stated above.
SIGNATURE *J. Edwin Fassett, M.D.* ADDRESS DATE SIGNED
*227 Pine St-Camb., Md.-8-14-56*23. BURIAL, CREMATION,
REMOVAL (SPECIFY)
Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL
REGISTRAR

Aug. 16, 1956

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Herbert M. St.Clair, Jr., Camb., Md.

BUREAU V. S.

UG 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118264

8291

CERTIFICATE OF DEATH

Reg. Dist. No. 116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rehoboth 80 yrs</i>		c. LENGTH OF STAY IN 1b <i>80 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>James Albert Cutten</i>		4. DATE OF DEATH <i>8/10/1956</i>	Month Day Year
SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/22/1868</i>
10a. PROFESSIONAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookbinder</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own business</i>	11. BIRTHPLACE (State or foreign country) <i>Wilmington, Delaware</i>
13. FATHER'S NAME <i>James C. Cutten</i>		14. MOTHER'S MAIDEN NAME <i>Sarah O'Day</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Brooklyn Cemetery Cutten</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Address <i>130 Race St Cambridge Md 21613</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
		6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>130 Race St Cambridge Md 21613</i>
		20f. (City or town) <i>Cambridge</i>	(County) <i>Md</i>
		(State) <i>21. I certify that I attended the deceased from 7/21/56 to 8/10/1956, that I last saw the deceased alive on 7/21/56, and that death occurred at 6:16 P.M. from the causes and on the date stated above.</i>	
ACTUAL SIGNATURE <i>Lawrence Maryanov</i>		ADDRESS (Street, city or town, state) <i>130 Race St Cambridge Md 21613</i>	
PHYSICIAN'S NAME (Type) <i>Lawrence Maryanov</i>		DATE SIGNED <i>8/11/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 8/13/56</i>		22b. DATE THEREOF <i>8/13/56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Methodist</i>		22d. LOCATION (City, town, or county) <i>Rehoboth Md</i>	
24a. FUNERAL DIRECTOR'S SIGNATURE <i>John Bellingsby, E. J. Market</i>		24b. ADDRESS <i>130 Race St Cambridge Md 21613</i>	
		DATE <i>Aug. 13, 1956</i>	

RECEIVED
BUREAU V. S.

UG 16 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 18265

8292 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: COUNTY Cambridge CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Linas Road		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Dorchester CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Linas Road STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) John Richard Abraham Phillips (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH 8 16 1956	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH: 1-2-1865
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday 91 IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME: unk		11. BIRTHPLACE (State or foreign country): Dor-Co-Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) unk		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. None		14. MOTHER'S MAIDEN NAME: Rhoda McNamara	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Cardiac Decompensation DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE (B) Arteriosclerotic heart disease DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 23 Jul, 1953, to 18 Aug, 1956, that I last saw the deceased alive on 18 Aug, 1956 and that death occurred at M, from the causes and on the date stated above. SIGNATURE <i>John Fassett</i> ADDRESS Edwin Fassett, M.D., 227 Pine St-Camb., Md. -8-18-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-19-56 NAME OF CEMETERY OR CREMATORIAL Linas Road Cemetery Linas Road, Md.	
DATE REC'D BY LOCAL REGISTRAR Aug. 19, 1956		24. FUNERAL DIRECTOR H. M. StSclair, Jr-High St-Camb., Md.	
REGISTRAR'S SIGNATURE <i>John Fassett, M.D.</i>		ADDRESS	

18. May 1956

106 22 1956

18. May 1956

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

118266

8293

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 16 Since 6/3/1953	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Martha		First	Middle
4. DATE OF DEATH R.D. #1		Month	Day
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH February 2, 1870		9. AGE (In years last birthday) 86	10. IF UNDER 1 YEAR, IF UNDER 24 HRS yrs Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? Unknown		13. FATHER'S NAME Paul Makurath	
14. MOTHER'S MAIDEN NAME Frances Secas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Eastern Shore State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Chronic Myocarditis		several years	
DUE TO Generalized Arteriosclerosis		several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 3, 1953 to August 4, 1956 that I last saw the deceased alive on August 4, 1956 , and that death occurred at 12:02 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert H. Reddick		ADDRESS (Street, city or town, state) M.D. State Hospital, Cambridge, Md. DATE SIGNED 8/4/56	
PHYSICIAN'S NAME (Type) Robert H. Reddick, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Aug. 8, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Holy Cross Cemetery	
22d. LOCATION (City, town, or county) Yeadon, Penna.		23. FUNERAL DIRECTOR'S SIGNATURE John H. H. Reddick	
24a. REGD BY REGISTRAR DATE Aug. 6, 1956		24b. REGISTRAR'S SIGNATURE John H. H. Reddick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUHLAU V. A.

REG. NO. 1056

BUHLAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08267

8294

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS -				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) John		First	Middle	Last	4. DATE OF DEATH August	Month	Day	Year				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-75	9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours	13. Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) railroad employee		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. no		17. INFORMANT RECORDS- Eastern Shore State Hosital		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia. INTERVAL BETWEEN ONSET AND DEATH 1 week												
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, lost. (b) Myocarditis. Several years (c) Generalized Arteriosclerosis.												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome Associated with Senile Brain Disease												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) St. Michaels		(County) Md.	(State) Md.			
21. I certify that I attended the deceased from July 28, 1956, to August 3, 1956, that I last saw the deceased alive on August 3, 1956, and that death occurred at 2:15 A.M., from the causes and on the date stated above.												
ACTUAL SIGNATURE Dr. Simon Virkutis		ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md.							DATE SIGNED August 3, 1956			
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug. 6, 1956							22b. DATE THEREOF Aug. 6, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Oliver Cemetery	22d. LOCATION (City, town, or county) St. Michaels, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE John Harrison		ADDRESS St. Michaels, Md.							24a. REC'D BY REGISTRAR John Harr. Ph. 8	24b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

ERNEST W. E.

AUG 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18268

8278

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS Race Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge MD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Carl J.		First	Middle	Last	4. DATE OF DEATH August 18 1956	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH February 28 1879	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Wittenburg-Baden, Germany		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME John George Singer		14. MOTHER'S MAIDEN NAME Caroline Swatz		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) Yes Spanish-American None		16. SOCIAL SECURITY NO. 17. INFORMANT August E. Singer Cambridge, R. F. D. MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 YEARS		CONGESTIVE HEART FAILURE		
		(b) DUE TO CORONARY ARTERY DISEASE				2 YEARS		
		(c) DUE TO SEVERE GENERAL ARTERIOSCLEROSIS				5 YRS.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 18 AUG 1956		20f. (City or town) Cambridge		(County) MD. (State)
21. I certify that I attended the deceased from 9 APRIL 1954 to 18 AUG 1956 that I last saw the deceased alive on 17 AUG 1956 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Cambridge		DATE SIGNED 20 Aug 56
ACTUAL SIGNATURE WALTER E. GUNBY JR.		PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 20, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge		(State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth P. Shouse, Andrews, Md.		ADDRESS 112 Main, R.D.		24a. REC'D. BY REGISTRAR Aug. 20, 1956		24b. REGISTRAR'S SIGNATURE John Doe, R.D.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X. E

AUG 23 1956

REGULIVEL

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the date and time of death in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; retention, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8295 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 6826/8

1. PLACE OF DEATH a. COUNTY Dorchester			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY Northampton		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurllock		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Exmore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Thomas	Middle N.	Last Taylor	4. DATE OF DEATH August 29 1956
5. SEX Male		6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 25, 1908	9. AGE (In years last birthday) 40 yrs.
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY farm labor		11. BIRTHPLACE (State or foreign country) Middlesex Co., Virginia	
13. FATHER'S NAME James R. Taylor		14. MOTHER'S MAIDEN NAME Mahaly Jones		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Virginia Bergwyn, Exmore, Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>coronary occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> ; Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL MURDER		DATE SIGNED 8/30/56			
EXAMINER'S NAME (Type) John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 9, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Bacon Hill Cemetery	22d. LOCATION (City, town, or county) Exmore, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE Sept 7/56	24b. REGISTRAR'S SIGNATURE Charles Hastings

3 A 30750

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6 130 250

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8296

CERTIFICATE OF DEATH

08270

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2mo. 18das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 409 Hammond Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Susie		First LOUISIA	Middle Tuttle	4. DATE OF DEATH August 15	Month 1956	Day 15	Year 1956
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-85		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Baxter Jewell		14. MOTHER'S MAIDEN NAME Frances Lamb					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO - - -		17. INFORMANT RECORDS-Eastern Shore State Hospital Mr. Frank S. Tuttle (Husband) 409 Hammond St. Salisbury, Maryland		Address INTERVAL BETWEEN ONSET AND DEATH 10 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia		DUE TO (b) Arteriosclerotic heart disease				Unkn.	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p.m. p.m.	Month 19	Day at work	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Salisbury, Maryland	(County)	(State)
21. I certify that I attended the deceased from May 28, 1956, to August 15, 1956, that I last saw the deceased alive on August 15, 1956, and that death occurred at 4:15 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. E.S.S. Hospital, Cambridge, Md. DATE SIGNED August 15, 1956							
ACTUAL SIGNATURE <i>George E. Currier</i>		PHYSICIAN'S NAME (Type) George E. Currier, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 17, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery	22d. LOCATION (City, town, or county) Salisbury, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		ADDRESS	24a. REC'D BY REGISTRAR DATE Aug. 16, 1956	24b. REGISTRAR'S SIGNATURE <i>John Maca. Jr.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him, it should be detached for use as the burial-transit permit. Then please return to the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 16 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial permit.

VS AISC 1-5 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8279

CERTIFICATE OF DEATH

08271

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		Dorchester		MARYLAND		STATE	
CITY (If outside corporate limits, write RURAL OR end give nearest town)				LENGTH OF STAY (In this place)		Md.	
TOWN		Cambridge,		7 days		CITY (If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Cambridge, Md. Hospital		STREET ADDRESS		COUNTY	
				High St.		Dorchester	
3. NAME OF (Type or Print)				4. DATE OF DEATH			
Wallace Clayton Vincent				Aug. 11 1956			
S SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	W	W	8/29/92	65	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Clerk				11. BIRTHPLACE (State or foreign country) Md. (Pocomoke)			
10b. KIND OF BUSINESS OR INDUSTRY hotel				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James F. Vincent				14. MOTHER'S MAIDEN NAME Dixon (Alice E.)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217-10-8607			
17. INFORMANT & ADDRESS Hospital Records							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Myocardial Infarction							
ANTECEDENT CAUSE(S) DUE TO (B) Coronary Sclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arterio Sclerosis, generalized							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Cambridge, Md.		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/1/56, 19....., to 8/11/56, 19....., that I last saw the deceased alive on 8/11/56 19..... and that death occurred at 7:15 AM from the causes and on the date stated above.							
SIGNATURE <i>Edridge H. Wolff</i> M.D. DATE SIGNED 8/12/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8/14/56		NAME OF CEMETERY OR CREMATORIAL Bethany Cemetery		LOCATION (City, town, or county) Pocomoke, Maryland	
24. REC'D BY REGISTRAR HIC 15 1012 DATE		REGISTRAR'S SIGNATURE <i>John Mace, Jr.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Henry A. Watson</i>		ADDRESS Pocomoke, Maryland	

UNIVERSITY OF TORONTO LIBRARIES

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08272

8297

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At. Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First SEWELL	Middle ANDREW	Last WILLEY	4. DATE OF DEATH 1951 August 1, 1956	Month Month	Day Day	Year Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 27, 1893	9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Andrews, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew H. Willey				14. MOTHER'S MAIDEN NAME Susan C. Booze			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Insley Willey Cambridge, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma				INTERVAL BETWEEN ONSET AND DEATH 24 mos			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Carcinoma of rectum				24. mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Abdominal peritoneal ligation 17/5/53 Johns Hopkins Hospital				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Locust St Cambridge Ma		(County) (State)	
21. I certify that I attended the deceased from 8/3 , 19 53 , to 8/1 , 19 56 , that I last saw the deceased alive on 8/1 , 19 56 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE W. H. Hanks M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 1, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Pk.		22d. LOCATION (City, town, or county) Cambridge	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Maryland		24a. REC'D. BY REGISTRAR Aug. 4 1956 John H. Hanks R.D.		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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BUHLER W.H.

AUG 4 1962

BUHLER W.H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8298

CERTIFICATE OF DEATH

18273

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester																										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b since 5/12/56		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Cambridge																												
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS R.F.D. # 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																										
3. NAME OF DECEASED (Type or print) William		First John	Middle Williams	Last Williams	4. DATE OF DEATH August 14, 1866	Month August	Day 8	Year 1956																								
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 14, 1866	9. AGE (in years from last birthday) 90	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0																								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dockmaster		10b. KIND OF BUSINESS OR INDUSTRY Marine		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.																										
13. FATHER'S NAME Anthony Williams			14. MOTHER'S MAIDEN NAME Isabelle Andrews																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Eastern Shore State Hospital Records		Address																										
<table border="1"> <tr> <td colspan="3">18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</td> <td colspan="3">INTERVAL BETWEEN ONSET AND DEATH 4 days</td> </tr> <tr> <td colspan="3">PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4422.1</td> <td colspan="3">Bronchopneumonia</td> </tr> <tr> <td colspan="3">DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)</td> <td colspan="3">Generalized Arteriosclerosis</td> </tr> <tr> <td colspan="3">DUE TO (c)</td> <td colspan="3">Chronic Myocarditis</td> </tr> </table>									18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH 4 days			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4422.1			Bronchopneumonia			DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)			Generalized Arteriosclerosis			DUE TO (c)			Chronic Myocarditis		
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DUE TO (c)			Chronic Myocarditis																													
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20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) State Hospital, Cambridge, Md.	(County)	(State)																								
<p>21. I certify that I attended the deceased from May 12, 1956 to August 8, 1956 that I last saw the deceased alive on August 8, 1956, and that death occurred at 5:40 P.M. from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) Robert H. Reddick</p> <p>ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Robert H. Reddick, M.D.</p> <p>DATE SIGNED 8/8/56</p>																																
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 11, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Calvary Cemetery		22d. LOCATION (City, town, or county) Somerville, Mass.																										
23. FUNERAL DIRECTOR'S SIGNATURE Renée L. Thomas Cambridge, Mass.		ADDRESS Flaherty Funeral Service, Somerville, Mass.		24a. RECD BY REGISTRAR Aug. 9, 1956		24b. REGISTRAR'S SIGNATURE John H. Flaherty, Jr.																										

DEPARTMENT OF COMMERCE - BUREAU OF THE CENSUS
CERTIFICATE OF DEATH

RECEIVED IN THE BUREAU OF THE CENSUS

AUG 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8280

CERTIFICATE OF DEATH

Reg. Dist. No. 18274

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishops Head		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital								
3. NAME OF DECEASED (Type or print)		First ANGIE	Middle MOORE	Last WOODLAND	4. DATE OF DEATH August 10 1956	Month August	Day 10	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 30, 1870	9. AGE (In years lost birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bishops Head, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Edward Moore		14. MOTHER'S MAIDEN NAME Not Known						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Arlie Woodland Bishops Head, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X		Cerebral thrombosis				INTERVAL BETWEEN ONSET AND DEATH 14 days		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)	generalized arteriosclerosis					
		(c)	Senility					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)	20f. (City or town) 8/10	(County)	(State)		
21. I certify that I attended the deceased from <u>7/29</u> , 19 <u>56</u> , to <u>8/10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/10</u> , 19 <u>56</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Cambridge, Md.		
ACTUAL SIGNATURE Dr. William H. Hanks M.D.						DATE/SIGNED 8/12/56		
PHYSICIAN'S NAME (Type)		Locust Stfeet, Cambridge, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/12/56	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park	22d. LOCATION (City, town, or county) Cambridge				(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Maryland	24a. REC'D. BY REGISTRAR Aug. 12, 1956	24b. REGISTRAR'S SIGNATURE John H. Lee, M.D.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4
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CERTIFICATE OF SERVICE

BUREAU X.

AUG 20 1956

RECEIVED